DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **12-07**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2013**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR Part 455 subpart E**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/12-09/30/12 $85,566** **b. FFY 10/01/12-09/30/13 $580,065**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Pages 79(aa), 79(ab), 79(ac)** ****Please see remarks**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:	
10. SUBJECT OF AMENDMENT: **Provider Screening and Other Enrollment Requirements under Medicaid**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**	
13. TYPED NAME: **Jason A. Helgerson**		
14. TITLE: **Medicaid Director** **Department of Health**		
15. DATE SUBMITTED: June 19, 2013		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED: **July 16, 2013**	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: **April 01, 2013**	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: **Michael Melendez**	22. TITLE: **Associate Regional Administrator** **Division of Medicaid and State Operations**	
23. REMARKS:		

FORM HCFA-179 (07-92)